

		FOR OHF USE					

LL 1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0007153</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>BURNSIDE NURSING HOME</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/01</u> to <u>06/30/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>410-412 N. SECOND ST.</u> <u>MARSHALL</u> <u>62441</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>CLARK</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Jackie Williams</u> (Title) <u>Administrator</u>	
Telephone Number: <u>(217) 826-2358</u> Fax # <u>(217) 826-2367</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>PATRICK E. BELL, CPA</u> (Firm Name & Address) <u>LARSSON, WOODYARD & HENSON, LLP</u> <u>702 E. COURT STREET PARIS, IL 61944</u> (Telephone) <u>(217) 465-6494</u> Fax # <u>(217) 465-6499</u>	
IDPA ID Number: <u>37-0841315001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>SEPT. 1963</u>			
Type of Ownership:			
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT			
<input checked="" type="checkbox"/> Charitable Corp.			
<input type="checkbox"/> Trust			
IRS Exemption Code _____			
<input type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
GOVERNMENTAL			
<input type="checkbox"/> State			
<input type="checkbox"/> County			
<input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>PATRICK E. BELL, CPA</u> Telephone Number: <u>(217) 465-6494</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BURNSIDE NURSING HOME# 0007153 Report Period Beginning: 07/01/01 Ending: 06/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds 12/06/01

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>119</u>	Skilled (SNF)	<u>105</u>	<u>40,537</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>119</u>	TOTALS	<u>105</u>	<u>40,537</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>16,619</u>	<u>15,957</u>		<u>32,576</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,619</u>	<u>15,957</u>		<u>32,576</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 80.36%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)Meals on Wheels

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started September 1963

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 06/30/02 Fiscal Year: 06/30/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

BURNSIDE NURSING HOME

0007153

Report Period Beginning:

07/01/01

Ending:

06/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	255,352	18,949	6,758	281,059		281,059		281,059		1
2	Food Purchase		169,347		169,347		169,347	(24,577)	144,770		2
3	Housekeeping	119,545	35,067		154,612		154,612		154,612		3
4	Laundry	75,485	26,459		101,944		101,944		101,944		4
5	Heat and Other Utilities			153,129	153,129		153,129		153,129		5
6	Maintenance	61,853	4,810	28,083	94,746		94,746		94,746		6
7	Other (specify):*										7
8	TOTAL General Services	512,235	254,632	187,970	954,837		954,837	(24,577)	930,260		8
	B. Health Care and Programs										
9	Medical Director			1,200	1,200		1,200		1,200		9
10	Nursing and Medical Records	1,385,602	104,932	10,192	1,500,726		1,500,726		1,500,726		10
10a	Therapy			6,845	6,845		6,845		6,845		10a
11	Activities	59,797	2,918	2,791	65,506		65,506		65,506		11
12	Social Services	30,725		2,791	33,516		33,516		33,516		12
13	Nurse Aide Training										13
14	Program Transportation			478	478		478		478		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,476,124	107,850	24,297	1,608,271		1,608,271		1,608,271		16
	C. General Administration										
17	Administrative	57,076			57,076		57,076		57,076		17
18	Directors Fees										18
19	Professional Services			87,097	87,097		87,097		87,097		19
20	Dues, Fees, Subscriptions & Promotions			19,273	19,273		19,273	(7,311)	11,962		20
21	Clerical & General Office Expenses	60,117	7,915	13,491	81,523		81,523		81,523		21
22	Employee Benefits & Payroll Taxes			336,646	336,646		336,646	(2,402)	334,244		22
23	Inservice Training & Education			527	527		527		527		23
24	Travel and Seminar			4,591	4,591		4,591		4,591		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			100,563	100,563		100,563		100,563		26
27	Other (specify):*										27
28	TOTAL General Administration	117,193	7,915	562,188	687,296		687,296	(9,713)	677,583		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,105,552	370,397	774,455	3,250,404		3,250,404	(34,290)	3,216,114		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

BURNSIDE NURSING HOME

#0007153

Report Period Beginning:

07/01/01

Ending:

06/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			116,645	116,645		116,645	(18,431)	98,214			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,586	35,586		35,586	(35,586)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			152,231	152,231		152,231	(54,017)	98,214			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,806	60,806		60,806		60,806			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			60,806	60,806		60,806		60,806			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,105,552	370,397	987,492	3,463,441		3,463,441	(88,307)	3,375,134			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BURNSIDE NURSING HOME

0007153

Report Period Beginning: 07/01/01

Ending: 06/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(24,577)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(35,586)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,000)	20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(460)	20		28
29	Other-Attach Schedule See pg 5a	(22,684)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (88,307)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (88,307)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

BURNSIDE NURSING HOME

ID# 0007153

Report Period Beginning: 07/01/01

Ending: 06/30/02

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	NON CARE DEPRECIATION	\$ (18,431)	30	1
2	EMPLOYEE RECOGNITION	(2,402)	22	2
3	PATIENT SUBSCRIPTIONS	(394)	20	3
4	OTHER ADVERTISING	(1,457)	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(22,684)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number **BURNSIDE NURSING HOME**# **0007153**

Report Period Beginning:

07/01/01

Ending:

06/30/02**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(24,577)	0	0	0	0	0	0	0	0	0	0	(24,577)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(24,577)	0	0	0	0	0	0	0	0	0	0	(24,577)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(7,311)	0	0	0	0	0	0	0	0	0	0	(7,311)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(2,402)	0	0	0	0	0	0	0	0	0	0	(2,402)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(9,713)	0	0	0	0	0	0	0	0	0	0	(9,713)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(34,290)	0	0	0	0	0	0	0	0	0	0	(34,290)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number **BURNSIDE NURSING HOME**# **0007153**

Report Period Beginning:

07/01/01

Ending:

06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(18,431)	0	0	0	0	0	0	0	0	0	0	(18,431)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(35,586)	0	0	0	0	0	0	0	0	0	0	(35,586)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(54,017)	0	0	0	0	0	0	0	0	0	0	(54,017)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(88,307)	0	0	0	0	0	0	0	0	0	0	(88,307)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
	NON-APPLICABLE					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$	NON-APPLICABLE		\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BURNSIDE NURSING HOME # 0007153 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NON-APPLICABLE								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BURNSIDE NURSING HOME # 0007153 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1				N/A	\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	UNION PLANTERS		X	MORTGAGE	\$5,972.00	08/17/01	\$ 394,245	\$ 356,513	06/15/10	7.0000	\$ 30,887	1	
2	MTS DIGITAL		X	LEASE TO PURCHASE	\$140.00	01/26/98	4,470		11/21/01	20.3000	34	2	
3	ONB		X	LINE OF CREDIT		11/3/01	200,000	166,077	11/04/02	4.7500	4,664	3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$6,112.00		\$ 598,715	\$ 522,590			\$ 35,585	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 598,715	\$ 522,590			\$ 35,585	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **BURNSIDE NURSING HOME**# **0007153** Report Period Beginning: **07/01/01** Ending: **06/30/02****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2001 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1997	8		
	1998	9		
	1999	10		
	2000	11		
	2001	12		

	FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2001	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME BURNSIDE NURSING HOME COUNTY CLARK

FACILITY IDPH LICENSE NUMBER 0007153

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

A.

Square Feet:

46,819

B.

General Construction Type:

Exterior

BDFDST/LIMEST

Frame

WOOD

Number of Stories

1

C.

Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.

Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Robert Flowers Village - Independent Living Facility - 8 units

Burnhavn Apartments - Independent Living Facility - 8 units

Cork Medical Center - provides outpatient medical care - leased to unrelated party

All of the above facilities have their own accounting records and share no common costs with Burnsidess Nursing Home.

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		226,425	1963	\$ 22,963	1
2		8,400	1982	12,376	2
3	TOTALS	234,825		\$ 35,339	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **BURNSIDE NURSING HOME**# **0007153**

Report Period Beginning:

07/01/01

Ending:

06/30/02**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4		1963	1963	\$ 823,909	\$ 10,776	15, 30	\$ 10,776	\$	\$ 791,705
5		1995	1995	1,100,822	27,521	30	27,521		190,129
6		1997	1997	737,255	18,431	20	18,431		87,571
7		1997	1997	(737,255)	(18,431)	20, 30	(18,431)		(87,571)
8									
Improvement Type**									
9	ELEVATOR	1965		8,581		20			8,581
10	SAFETY DOORS AND IMPROVEMENTS	1972		9,375		10			9,375
11	IMPROVEMENTS	1974		4,562		10			4,562
12	SPRINKLER SYSTEM	1975		39,041		20			39,041
13	IMPROVEMENTS	1977		2,892		10			2,892
14	IMPROVEMENTS	1978		636		10			636
15	IMPROVEMENTS, DRAPES	1979		11,842					11,842
16	AWNING, DINING ROOM WINDOWS	1981		21,654	388	10, 30	388		21,654
17	DRAPES, GUTTERING, DRAINAGE, DINING ROOM ROO	1982		13,093					13,093
18	DRAPES	1983		5,526		15			5,526
19	DRAPES, LIGHTING, & KITCHEN CABINET DOORS	1984		7,163		10, 15			7,163
20	FIRE SYSTEM KITCHEN, DRAPES, STEEL WALL KITCHEN	1985		25,083	754	5, 25	754		22,637
21	LIGHTS, CALL SYSTEM, REMODELING, DRAPES, ROOF	1986		67,975	1,312	5, 25	1,312		66,127
22	SPRINKLERS, CARPET, DRAPES	1987		9,272	488	5, 25	488		7,860
23	BUILDING IMPROVEMENTS, WATER PUMP, SEWER	1988		9,350	449	8, 20	449		7,011
24	SMOKE DETECTOR, REMODELING, AIR CONDITIONER	1989		31,888	2,370	5, 20	2,370		21,116
25	DOOR ALARM, FIRE ALARMS, REMODELING	1990		13,402	355	10, 20	355		10,598
26	REMODELING	1991		5,798	139	10, 20	139		4,742
27	OFFICE REMODELING DOOR	1993		8,177	786	10, 20	786		7,206
28	WATER SYSTEM, WINDOW	1994		5,079	352	10, 20	352		2,824
29	NEW WING ADDITION	1995		88,453	5,224	10, 20	5,224		35,759
30	WALLPAPER, BLINDS, PHONE SYSTEM	1996		4,335	217	20	217		1,340
31	CEILING WORK, INSULATION	1997		24,991	1,250	20	1,250		5,989
32	BACKFLOW SYSTEM/SPRINKLER SYSTEM	1998		2,990	150	20	150		611
33	ROOFING, REMODELING	1999		41,517	2,124	10, 20	2,124		7,422
34	DRAPERIES MAIN DINING ROOM	2000		2,735	273	10	273		547
35	WINDOWS DINING ROOM	2000		3,620	241	15	241		463
36	SPRINKLER HEAD	2001		560	22	15	22		22

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	PARKING LOT	1973	\$ 19,280	\$	10	\$	\$	\$ 19,280		37
38	LANDSCAPING	1974	2,891		10			2,891		38
39	PARKING LOT IMPROVEMENT	1975	3,989		10			3,989		39
40	BLACKTOP SEALING, CULVERT INSTALLATION	1980	13,853		10			13,853		40
41	BLACKTOP AT SHED, SEWER	1981	5,170		15			5,170		41
42	LANDSCAPING, GRADING, PARKING LOT IMPROVEMENTS	1982	15,497		5, 15			15,497		42
43	ASPHALT SEALING	1983	3,511		5			3,511		43
44	LANDSCAPING, ROAD IMPROVEMENT	1984	4,350		5, 10			4,350		44
45	LANDSCAPING AT CHAPEL	1988	675		10			675		45
46	LANDSCAPING	1989	220		10			220		46
47	ROAD RESURFACINT	1990	9,188	593	5, 15	593		7,507		47
48	ROCK	1992	330	28	10	28		330		48
49	ASPHALT SEALING	1993	20,570		5			20,570		49
50	LANDSCAPING, FIRE HYDRANT	1995	4,807	294	10, 20	294		2,103		50
51	PARKING LOT PAVING	1999	11,850	1,185	10	1,185		4,740		51
52	LANDSCAPING	2000	500	33	19	33		91		52
53	CHAPEL	1985	229,191	7,284	10, 30	7,284		135,111		53
54	DRAPERIES AND CARPET	1986	4,252		20			4,252		54
55	ROOF - NEW SHINGLES	2002	3,820	21	15	21		21		55
56	ROOF ON GARAGE	2000	791	53	15	53		92		56
57										57
58										58
59	IDPA DESK REVIEW RECLASSIFICATION		18,478	1,432		1,432		13,400		59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 2,767,534	\$ 66,114		\$ 66,114	\$	\$ 1,566,126		70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 352,151	\$ 32,074	\$ 32,074	\$	10	\$ 211,315	71
72	Current Year Purchases	24,576	1,458	1,458		10	1,458	72
73	Fully Depreciated Assets	151,845				10	151,845	73
74	IDPA RECL DESK REV	(18,478)	(1,432)	(1,432)			(13,400)	74
75	TOTALS	\$ 510,094	\$ 32,100	\$ 32,100	\$		\$ 351,218	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	LOCAL TRNSPTN	1981 GMC RALLY VAN	1981	\$ 13,873	\$	\$		5	\$ 13,873	76
77	LOCAL TRNSPTN	1987 DODGE PICKUP	1987	8,212				5	8,212	77
78										78
79										79
80	TOTALS			\$ 22,085	\$	\$	\$		\$ 22,085	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,335,052	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 98,214	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 98,214	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,939,429	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>N/A</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ _____			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: N/A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ <u>N/A</u>	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$ _____

13. /2004 \$ _____

14. /2005 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8			
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service	Cost	Units	Cost						
					1	Licensed Occupational Therapist		hrs	\$		\$	N/A
	Licensed Speech and Language											
2	Development Therapist		hrs									2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist		hrs									4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy		# of prescrpts									9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)											
10			hrs									10
11	Academic Education		hrs									11
12	Exceptional Care Program											12
13	Other (specify):											13
14	TOTAL			\$		\$	\$		\$	#VALUE!	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (6,423)	\$	1
2	Cash-Patient Deposits	3,278		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	256,684		3
4	Supply Inventory (priced at)	26,671		4
5	Short-Term Investments	426,742		5
6	Prepaid Insurance	84,578		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>INTEREST REC</u>	205		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 791,735	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	35,339		13
14	Buildings, at Historical Cost	2,661,985		14
15	Leasehold Improvements, at Historical Cost	824,325		15
16	Equipment, at Historical Cost	550,657		16
17	Accumulated Depreciation (book methods)	(2,026,999)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,045,307	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,837,042	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 112,293	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	173,302		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,362		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	957		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>TRUST ACCOUNT</u>	3,278		36
37	<u>SHORT TERM PORTION OF LTD</u>	214,309		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 526,501	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	308,281		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to Robert Flowers Village</u>	226,200		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 534,481	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,060,982	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,776,060	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,837,042	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,143,013	1
2	Restatements (describe):		2
3	Prior Period Reclassification	(60,000)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,083,013	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(312,953)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (312,953)	17
	B. Transfers (Itemize):		
18	INTERDIVISIONAL TRANSFER	6,000	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 6,000	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,776,060	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,077,186	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,077,186	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	532	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 532	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	24,577	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 24,577	23
	D. Non-Operating Revenue		
24	Contributions	11,107	24
25	Interest and Other Investment Income***	36,239	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 47,346	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income 854, Sale of Fixed Asset -7	847	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 847	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,150,488	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	954,837	31
32	Health Care	1,608,271	32
33	General Administration	687,296	33
	B. Capital Expense		
34	Ownership	152,231	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	60,806	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,463,441	40
41	Income before Income Taxes (line 30 minus line 40)**	(312,953)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (312,953)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **BURNSIDE NURSING HOME**# **0007153**Report Period Beginning: **07/01/01**

Ending:

06/30/02**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,136	\$ 45,493	\$ 21.30	1
2	Assistant Director of Nursing	2,040	2,194	41,345	18.84	2
3	Registered Nurses	13,993	15,409	246,176	15.98	3
4	Licensed Practical Nurses	18,881	20,672	260,416	12.60	4
5	Nurse Aides & Orderlies	86,436	93,029	734,303	7.89	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,564	6,212	57,869	9.32	8
9	Activity Director	1,950	2,040	18,398	9.02	9
10	Activity Assistants	5,515	5,995	41,399	6.91	10
11	Social Service Workers	2,704	2,738	30,725	11.22	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,096	18,788	8.96	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,669	32,028	236,564	7.39	15
16	Dishwashers					16
17	Maintenance Workers	4,673	5,153	61,853	12.00	17
18	Housekeepers	16,541	17,691	119,545	6.76	18
19	Laundry	9,271	10,055	75,485	7.51	19
20	Administrator	2,080	2,104	57,076	27.13	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,123	2,147	26,266	12.23	23
24	Clerical	3,756	4,194	33,851	8.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	209,356	225,893	\$ 2,105,552 *	\$ 9.32	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	150	\$ 6,758	1-3	35
36	Medical Director	Mo fee	1,200	9-3	36
37	Medical Records Consultant	Mo fee	1,725	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Mo fee	1,200	10-3	39
40	Physical Therapy Consultant	Per Visit	6,845	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	31	2,791	11-3	44
45	Social Service Consultant	69	2,791	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	250	\$ 23,310		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses	N/A		51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Jackie Williams	Administrator	.00	\$ 57,076
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 57,076
B. Administrative - Other			
Description			Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
Larsson, Woodyard & Henson	Accounting		\$ 11,860
Duane,Morris & Heckscher, LLP	Legal services		68,925
Larsson, Woodyard & Henson	Computer serv		5,418
Other	Adm Consult.		894
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 87,097
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 45,618
Unemployment Compensation Insurance			6,857
FICA Taxes			159,991
Employee Health Insurance			61,686
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Flex contributions			57,010
Flex Administration			3,082
Employee Recognition			2,402
TOTAL (agree to Schedule V, line 22, col.8)			\$ 336,646
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			269
Health Care Worker Background Check (Indicate # of checks performed 11)			132
Dues & Subscriptions			9,598
Fees			7,358
Other advertising			1,916
IDPA fine			(5,000)
Patient Subscriptions			(394)
Less: Public Relations Expense			(
Non-allowable advertising			(1,457)
Yellow page advertising			(460)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 11,962
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			4,591
Entertainment Expense			(
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 4,591

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9			N/A										
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BURNSIDE NURSING HOME

STATE OF ILLINOIS

0007153

Report Period Beginning:

07/01/01

Ending:

Page 23

06/30/02

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IHCA \$ 6,910
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 52,343 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 60,806
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount. \$ 24,577
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: LARSSON, WOODYARD & HENSON, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.